NON-PUBLIC?: N

ACCESSION #: 8910190282

LICENSEE EVENT REPORT (LER)

FACILITY NAME: Joseph M. Farley - Unit 2 PAGE: 1 OF 3

DOCKET NUMBER: 05000364

TITLE: Reactor Trip Caused By Inadvertent Opening Of the Overspeed Trip

Test Valve

EVENT DATE: 09/20/89 LER #: 89-010-00 REPORT DATE: 10/12/89

OTHER FACILITIES INVOLVED:

OCKET NO: 05000

OPERATING MODE: 1 POWER LEVEL: 061

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR

SECTION: 50.73(a)(2)(iv)

LICENSEE CONTACT FOR THIS LER:

NAME: D. N. Morey General Manager - Nuclear Plant

TELEPHONE: 205-899-5156

COMPONENT FAILURE DESCRIPTION:

CAUSE: SYSTEM: COMPONENT: MANUFACTURER:

REPORTABLE NPRDS:

SUPPLEMENTAL REPORT EXPECTED: NO

ABSTRACT:

At 0722 on 9-20-89, with the unit operating at approximately 61% power, the reactor was tripped manually following the loss of the operating steam generator feed pump (SGFP). The 2A SGFP turbine tripped due to a low auto-stop oil pressure signal. The Shift Supervisor directed a manual reactor trip in order to prevent an unnecessary challenge to the reactor protection system. The unit was stabilized in Mode 3 (Hot Standby).

The low auto-stop oil signal was caused by the inadvertent opening of the overspeed trip test valve. Opening this valve lowered auto-stop oil pressure by diverting auto-stop oil to the overspeed test device.

Auto-stop oil pressure dropped below the as-found trip set point of the

low auto-stop oil pressure switch causing a SGFP trip. The trip setpoint was found to be higher than it should have been.

The unit returned to power operation at 2003 on 9-26-89.

END OF ABSTRACT

TEXT PAGE 2 OF 3

Plant and System Identification:

Westinghouse - Pressurized Water Reactor Energy Industry Identification System codes are identified in the text as XX!.

Summary of Event

At 0722 on 09-20-89, with the unit operating at approximately 61% power, the reactor AB! was tripped manually following the loss of the operating steam generator feed pump (SGFP) SJ!. The 2A SGFP turbine tripped due to a low auto-stop oil pressure signal. The Shift Supervisor directed a manual reactor trip in order to prevent an unnecessary challenge to the reactor protection system. The unit was stabilized in Mode 3 (Hot Standby).

Description of Event

On 09-20-89, the 2B SGFP had been removed from service to repair an electro- hydraulic fluid leak. Therefore, the unit was operating at approximately 61% power. The 2A SGFP was providing feedwater to the steam generators. At 0722, the 2A SGFP turbine tripped when a worker, who was taking measurements, inadvertently bumped the overspeed trip test valve lever and the valve opened. This lever is in a location that is not easily accessible. The worker was climbing between the SGFP skid and the SGFP seal piping.

Normally, opening this test valve with the pump in service would cause a pump trip to occur due to the actuation of the overspeed trip device. However, in this event, the pump tripped on low auto-stop oil pressure due to an inoperable overspeed test device. Excessive clearances in the overspeed test device prevented it from actuating the overspeed trip but caused a drop in auto-stop oil pressure when the test valve was opened. The oil pressure dropped below the as-found SGFP trip setpoint of the auto-stop oil pressure switch. During subsequent testing, the setpoint of the auto-stop oil pressure switch was found to be higher than it should have been.

The mechanical overspeed trip for the SGFP was always operable.

Following the trip, the operators implemented FNP-2-EEP-0 (Reactor Trip or Safety Injection) and FNP-2-ESP-0.1 (Reactor Trip Response), ensuring that the unit was safely in Mode 3. The unit was maintained in a stable condition.

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Cause of Event

This event was caused by personnel error in that an individual inadvertently bumped the overspeed trip test lever causing the valve to open.

Reportability Analysis and Safety Assessment

This event is reportable because of the manual actuation of the reactor protection system. After the trip, the following safety systems operated as designed: main feedwater was isolated with flow control valves and bypass valves closed, auxiliary feedwater pumps started automatically and provided flow to the steam generators, source range nuclear instrumentation automatically energized, and pressurizer heaters and spray valves operated automatically as required to maintain system pressure. There was no effect on the health and safety of the public.

Corrective Action

The individual involved in this event has been counseled to be more aware of his surroundings and any hazards that may be present when working in tight areas. The overspeed trip test lever has been restrained to prevent inadvertent opening of the valve.

In addition, the overspeed trip test device has been worked to ensure proper clearance and the setpoint of the auto-stop oil pressure switch has been corrected.

Additional Information

The unit returned to power operation at 2003 on 09-26-89.

No components failed during this event.

This event would not have been more severe if it had occurred under different operating conditions.

ATTACHMENT 1 TO 8910190282 PAGE 1 OF 1

Alabama Power Company 40 Inverness Center Parkway Post Office Box 1295 Birmingham, Alabama 35201 Telephone 205 868-5581

W. G. Hairston, Ill Senior Vice President Nuclear Operations AlabamaPower

October 12, 1989

southern electric system 10 CFR 50.73

Docket No. 50-364

U. S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, D.C. 20555

Dear Sir:

Joseph M. Farley Nuclear Plant - Unit 2 Licensee Event Report No. LER 89-010-00

Joseph M. Farley Nuclear Plant, Unit 2, Licensee Event Report No. LER 89-010-00 is being submitted in accordance with 10CFR50.73. If you have any questions, please advise.

Respectfully submitted, W. G. Hairston, III WGH,III/JAR:md 8.32

Enclosure

cc: Mr. S. D. Ebneter Mr. G. F. Maxwell

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